SUPPORTING A GOOD LIFE: TRANSFORMING HEALTH AND SOCIAL CARE IN THURROCK

Improving life not just services

Essex Partnership University NHS Foundation Trust

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Thurrock CVS

Thurrock Coalition 01375 389864 be part of the solution

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NHS Mid and South Essex University Hospitals Group

NHS Thurrock Clinical Commissioning Group

Acknowledgements

We would like to acknowledge the hard work and commitment of the following people without whom the Thurrock journey past, present and future, would not have been possible:

- Ian Wake, Director of Public Health, Thurrock Council
- Les Billingham, Director of Adult Social Care, Thurrock Council
- Tania Sitch, Integrated Care Director, Thurrock Council and NELFT NHS Foundation Trust
- Rita Thakaria, Assistant Director, Community Care and Crisis, NELFT NHS Foundation Trust
- Sue Waterhouse, Director of Mental Health, Essex Partnership University NHS Foundation Trust
- Lynnbritt Gale, Associate Director, Community Mental Health, Essex Partnership University NHS Foundation Trust
- Kristina Jackson, Chief Executive, Thurrock Community and Voluntary Sector
- Kim James, Chief Operating Officer, Thurrock Community and Voluntary Sector
- Ian Evans, Director, Thurrock Coalition
- Nicola Windsor, Transformation Programme Lead, NELFT NHS Foundation Trust
- Mark Tebbs, Director of Commissioning, NHS Thurrock Clinical Commissioning Group
- Ian Stidston, Director of Commissioning, NHS Thurrock Clinical Commissioning Group
- Catherine Wilson, Strategic Lead for Commissioning, Thurrock Council
- Fran Leddra, Strategic Lead for Adult Social Care, Thurrock Council
- Jeanette Hucey, Director of Transformation, NHS Thurrock Clinical Commissioning Group
- Sharon Hogarth, Area Manager, College Health
- Dan Turner, Head of Integrated Care, Basildon and Thurrock University Hospitals NHS Foundation Trust
- Christopher Smith, Programme Manager Adult Social Care, Thurrock Council
- Louise Banks, Head of Communications and Engagement, NHS Thurrock Clinical Commissioning Group
- Carla Fourie, Associate Director for Social Care, Essex Partnership University NHS Foundation Trust

In addition:

- Jenny Pitts—National Development Team for Inclusion
- Sian Lockwood and Helen Allen—Community Catalysts
- Helen Sanderson—Wellbeing Teams
- Cormac Russell—Nurture Development
- Ralph Broad—Local Area Coordination

SUPPORTING A GOOD LIFE:TRANSFORMING HEALTH AND SOCIAL CARE IN THURROCK

Foreword

Corporate Director of Adults, Housing and Health, **Roger Harris** and Accountable Officer of NHS Thurrock Clinical Commissioning Group, **Mandy Ansell**

Thurrock has a history of strong partnership working across health and care and with the voluntary and community sector. It is our strong commitment to each other and to Thurrock people that has allowed us to craft such a unique and creative response to some of the most difficult challenges we face.

Our driving force is our desire to improve outcomes - finding integrated solutions that deliver what's important to people, putting them firmly in the driving seat. This has meant treasuring and nurturing the assets available within our communities and seeing them as central to improving health and wellbeing. It has also meant statutory organisations learning to 'lose control'.

Our success is inextricably linked to our ability to strengthen what's available close to home and to the ability to ensure this system can focus on prevention and early intervention.

We are keen through this Prospectus to reflect the success we've achieved through system redesign, and equally keen to document what we've learnt and the challenges we've had to overcome on the way.

We've written this document to capture in one place how we've arrived at our current destination and to be able to note our achievements, but also so others can learn from our approach.

We'd like to end by thanking system partners and the community for their continued commitment to making change happen and by being prepared to take the leap of faith required to do more than just move the deckchairs.

Roger Harris
Corporate Director
Adults, Housing and Health
Thurrock Council

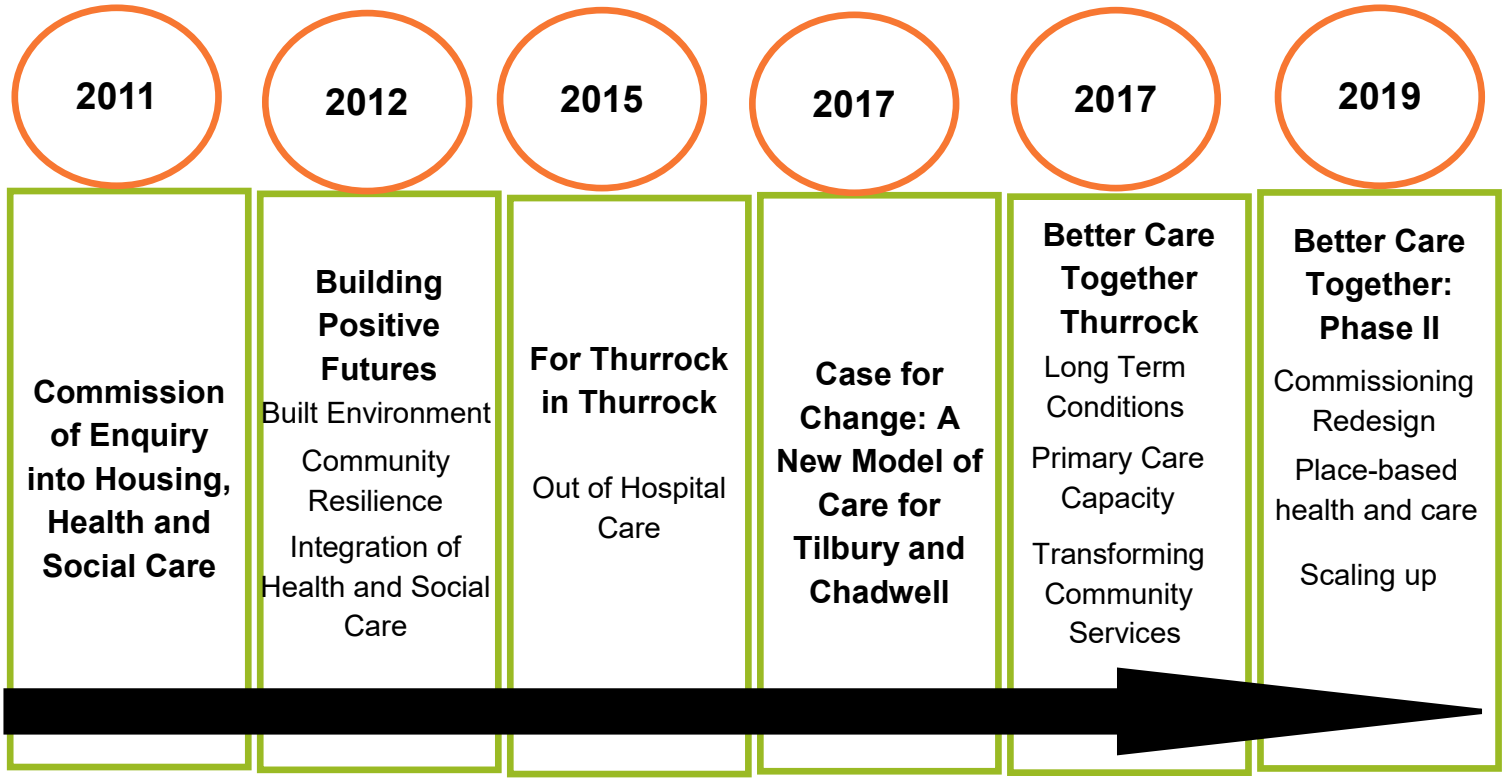
Mandy Ansell
Accountable Officer
NHS Thurrock Clinical Commissioning Group

Introduction and Background

This paper sets out Thurrock's approach to transforming the Health and Social Care landscape. It summarises the steps that were taken from 2011, when the Adult Social Care-led inaugural approach known as 'Building Positive Futures was established, followed in 2015 by the NHS-led approach 'For Thurrock in Thurrock', up to our current integrated system redesign programme - **Better Care Together Thurrock.**

This paper identifies what we see as the key reasons for success, but also the key barriers that that have stood in the way of progress. Fundamentally, the paper articulates what we see as building blocks of a 21st Century Health and Social Care system.

Our Transformation Journey



BUILDING THE FOUNDATIONS

Our response to the Ageing Well agenda

2011 **Commission of Enquiry into Cooperation between Housing, Health and Social Care across local authorities in South Essex**

The Commission of Enquiry helped to highlight the importance of the built environment in:

a) Keeping people out of hospital and ensuring that they could return home safely upon discharge; and

b) Contributing positively to health and wellbeing

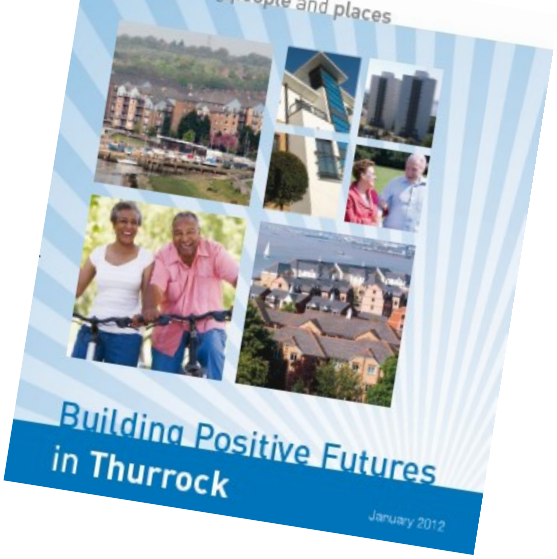
2011 **Stronger Together Thurrock**

The Commission of Enquiry highlighted the importance of 'community' as part of the 'Ageing Well' agenda. As a result, the Council embarked on a community resilience building programme, based on Asset Based Community Development. This led to the establishment of Stronger Together Thurrock. Stronger Together Thurrock is a partnership of the Third Sector, Communities, Council and Health.

This early approach was pivotal in showing that the agenda for overcoming and the ability to overcome substantial challenges was broader than health and social care. In this early stage, it was about what partners could do to influence how well people aged, and how well people were able to manage their impairment or condition—which would help to contain demand for already stretched services.

The response to the Commission of Enquiry, including the establishment of Stronger Together Thurrock, led to the first phase of an Adult Social Care-led transformation programme known as **Building Positive Futures.**

BUILDING POSITIVE FUTURES 2012



Reflecting the findings of the Commission of Enquiry:

⇒ **Creating the homes and neighbourhoods that support independence (the 'built' environment)**

⇒ **Creating the communities that support health and wellbeing ('stronger' communities)**

⇒ **Creating the right social care and health infrastructure to manage demand**

Stronger Communities

Through the establishment of Stronger Together Thurrock, there was a growing understanding of the way in which the whole philosophy underpinning the delivery of health and social care needed to change.

Stronger Together engaged with Cormac Russell from Nurture Development who helped to support local thinking on **Asset Based Community Development (ABCD)**. Cormac's approach challenged the common deficit-based model that statutory services commonly used that tried to 'fix' people problems – this focus on need and a medical model often achieved the complete opposite.

The adoption of the ABCD **'what's strong' not 'what's wrong'** ethos led to a number of initiatives being implemented:

Local Area Coordination

- Supporting people to achieve their vision of a 'good life'
- Reducing service reliance and loneliness and isolation
- Connecting communities
- Using and encouraging community building
- Avoiding crisis

Community Hubs

- Six community-led Hubs opened
- Providing space for communities to connect and access information and advice

Time Banking

- Enabling people to help others and bank the time they had spent doing so
- Using or gifting the 'banked' time for something in return

Social Prescribing

- Providing GPs with a non-clinical route for people requiring a non-clinical solution

Micro Enterprises

- Encouraging and supporting the development of micros
- Giving people more choice
- Helping local people in to employment and volunteering
- Keeping economic activity local

The Built Environment

We understood and wanted to influence the positive impact of the built environment on health and wellbeing and did so in a number of ways.

HAPPI Housing

⇒ Collaboration with one of the architects involved with the Housing Our Ageing Population Panel (known as HAPPI housing).

⇒ Adopting ten key HAPPI design principles to ensure that housing for people as they grew older was not only adaptable to changing circumstances, but also helped to facilitate good wellbeing. For example the importance of natural light and design that facilitated connections to avoid isolation.

⇒ Developing one HAPPI housing scheme and commissioning the development of another.

Bruyn's Court, South Ockendon

Independent Living for Adults of Working Age

⇒ Developing a supported housing scheme for young adults – facilitated by securing grants from the Care and Support Specialised Housing Fund (CASSH).

⇒ Decommissioning and repurposing sheltered housing creating a number of flats for learning disabled adults to live independently

Medina Road, Little Thurrock

Housing and Planning Advisory Group (HPAG)

⇒ Sub-group of the Health and Wellbeing Board

⇒ Providing a forum through which the built environment could be influenced across the Borough.

⇒ Representation from Planning, Regeneration, Police, Health (Estates and CCG), Public Health, Children's Services, Housing, and Adult Social Care

⇒ All major developments brought to the Group for consideration and comment

⇒ Consideration and input in to key policy documents—Including the Local Plan

The Integration of Health and Social Care

The enactment of the Health and Social Care Act 2012, the creation of Clinical Commissioning Groups (CCGs), the development of Health and Wellbeing Boards and the requirement for Better Care Fund Plans all meant that the integration of health and social care was high up on the agenda. Through Building Positive Futures, a shared agenda progressed, resulting in the following:

Integrated Care Director

A shared post between the Council and Community Health Provider (NELFT NHS Foundation Trust)

Single Point of Access

The development of a single point of access **'Thurrock First'** across Adult Social Care, Mental Health and Community Health—developed through shared funding and accountability and focusing on 'solutions' not 'services' and providing information and advice

Thurrock's Mayfield Ward

A new integrated physical and mental health rehabilitation facility in the community

Older Adults Health and Wellbeing Service

Launched in 2016, the award winning integrated service provides support to care and residential homes with the aim of reducing the need for a hospital admission and to improve the quality of care.

Rapid Response and Assessment Team

With staff spanning social care and community health, an integrated team aimed at providing a rapid response to people in or approach crisis—reducing unnecessary admissions.

Integrated Care Team

Providing a wide range of nursing care, physiotherapy and occupational therapy across Thurrock—mainly to housebound patients

Better Care Fund Plan

A plan that allowed us to articulate a shared vision, shared aspirations, and shared consultation and agreement of investments—now containing over £48m

Dementia Crisis Support Team

The award-winning Team provides short-term support to manage crisis and try to avoid admission to hospital

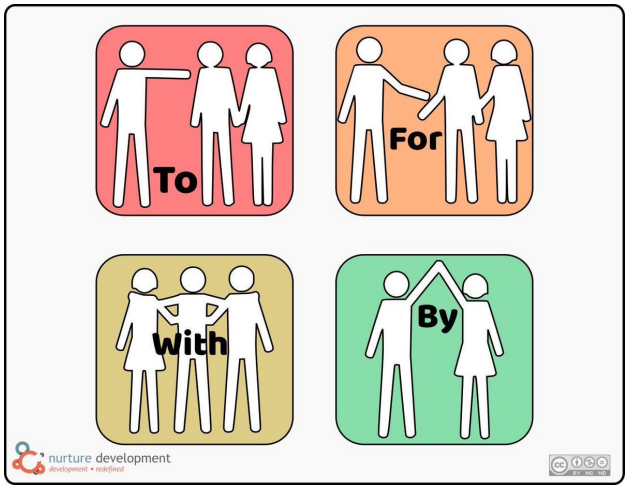
Joint Reablement Team

providing an integrated health and social care approach to reablement

Strengths-Based Social Work

For some time, the default position nationally for people requiring support from Adult Social Care was a service response delivered to those who were assessed as 'eligible'. This approach was process-driven and designed to deliver a 'one size fits all solution'. This was a way of working that had developed over the years and was influenced by national performance requirements and outdated policy requirements. This told us little about the impact of what we were providing or the difference it was making to someone's quality of life. Through the years the social care workforce had become disempowered with their ability to be creative limited.

Through the establishment of Stronger Together and its adoption of Asset Based Community Development (ABCD), we recognised the value of focusing on people's strengths and gifts – a shift to 'what's strong' rather than 'what's wrong'.

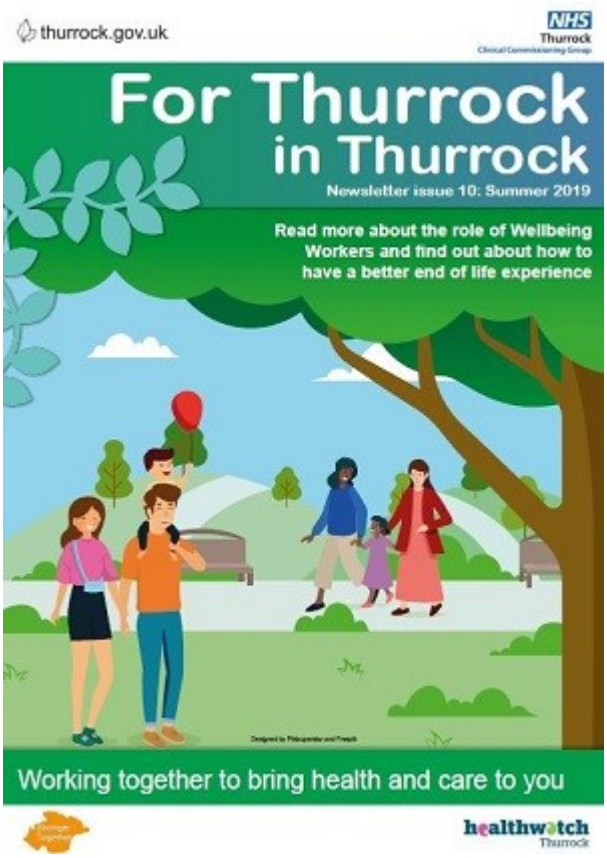


The work of Stronger Together and Cormac Russell (Nurture Development) helped us to rethink social work and placed it in a community context. This included a series of workshops for social work teams on strength-based working and a redraft of our assessment model – with the focus on strengths and outcomes rather than needs and outputs.

The change in our approach was helped and supported by the implementation of Local Area Coodination. We had utilised social work vacancies to employ three Local Area Coordinators (LACs). Having LACs in post showed us what could be achieved through working in a strength-based way and also identifying people before they entered 'service-land'. LACs were able to work in a 'place-based' way. They identified or facilitated community assets and they evidenced the importance of utilising non-service solutions. LACs were also able to minimise bureaucracy by using minimal paperwork or process. As a result of their work, numerous case studies were gathered. The case studies showed reductions in service packages, improvements in health and wellbeing, and reductions in service-dependency. LAC also showed what could be done when staff were empowered and given the permission to do what they thought was right. Recruiting people with the right values was essential to the initiative's success. Through LAC and Stronger Together we started to build a community asset map. For the first time this gave social workers information that they could use to provide non-service solutions.

Based on this early success, we were able to expand to fourteen LACS. This was made possible by funding received from partners as well as social care. LAC was pivotal in proving the case for strength based and locality working. This would prove vital in future transformation work.

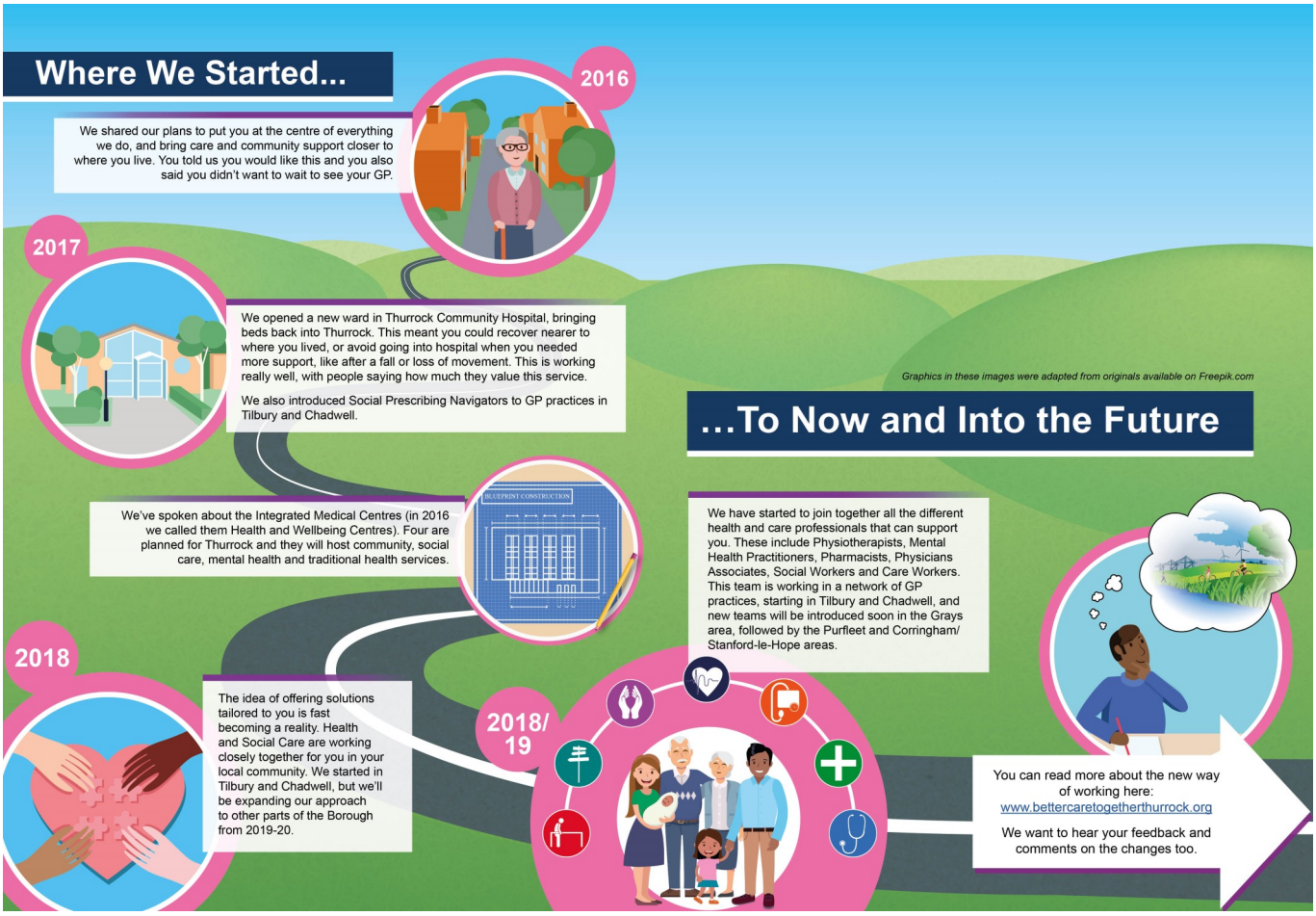
For Thurrock in Thurrock—Local NHS Transformation Programme



During the first phase of transformation, Adult Social Care led on Building Positive Futures—being in a position to influence the built environment and the stronger communities agenda. At a similar time, NHS Thurrock Clinical Commissioning Group launched a programme known as For Thurrock in Thurrock (FTIT). The initial focus of FTIT was to move intermediate care beds in to the Borough so that Thurrock residents could be placed near to where they lived.

Over time, FTIT expanded its brief to include the development of four Integrated Medical Centres across the Borough and to launch initiatives such as Social Prescribing.

Both the NHS and Council transformation agendas developed so that by the time a further phase of transformation was ready to be launched, the vision, aims and objectives of the two agendas were synonymous.



Learning for the future—what did BPF teach us?

Building Positive Futures gave us invaluable lessons from which we were able to review, consolidate and advance:

a) Feeling the fear and doing it anyway….

A number of the initiatives introduced were relatively new and untested. They were a departure from the 'norm' and viewed with uncertainty by many.

Doing the same as we had always done and 'tweaking' existing services would not provide the solution required. The approach to providing health and social care, built up over the previous 70 plus years, had foisted dependency and a 'professionals knows best' culture - a system that was built to react to crisis. Holding on to our belief about how the system needed to change and supporting initiatives that would help us to achieve the shift required has become a theme throughout our journey - but initially took real courage and a leap of faith. Strong leadership was essential.

b) Collaboration of the willing

Much of what we achieved during the Building Positive Futures phase was because we aligned and collaborated with people who wanted to make change happen and shared our vision. This included building a close and equal partnership with the third sector through Thurrock CVS.

Access to certain communities and community organisations could not have been gained without the relationship with the third sector having been in place. The development of many of our approaches were only successful as a result of third sector support, advice and buy-in.

A significant proportion of the shift towards a strength based model of working has been as a result of the work undertaken by and through the Stronger Together Thurrock partnership. This is not a formal partnership, but a coalition of people across different organisations and groups with similar views and the passion and influence to make a difference. The organic nature of this collaboration, along with the deep sense of trust that resulted from such a partnership, were to become touchstones of our transformation approach.

Change is difficult at the best of times, but when it requires challenging the very foundations that have underpinned how health and care has developed and been delivered over decades, it is impossible to get everyone on board quickly. We have found that it is far easier to work with people who see things the same way and then pull others along once the case has been proven, rather than to waste energy and time convincing the doubters.

c) Taking Opportunities

Much of what we were able to progress early on was because we took advantage of opportunities that arose. For example, we were able to secure funding through the Homes and Community Agency's Care and Support Specialist Housing Fund (CASSH) to fund HAPPI housing schemes for older people and a supported living scheme for young adults.

We were also able to use vacant social worker posts to proceed with our initial Local Area Coordination work – allowing us to recruit three posts and to build a solid business case based on the success of the early pilot.

d) Letting people take their own risks—challenging our own thinking

A key learning point early on in our journey was the importance of letting people assess and take their own risks. Taking informed risks is essential to being able to shift systems away from what is safe but failing, toward what is innovative and has the potential for real improvement. One of the reasons for statutory organisations being fearful of initiatives such as Local Area Coordination is because of individuals potentially taking risks by being connected to others in their community without processes such as DBS or risk assessments being applied. The 'outcome' and often far greater risk - i.e. that people are left lonely and isolated, is not always given due consideration - or the fact that people take risks mostly successfully in their lives every day in deciding who they do and do not connect with.

Shifting towards a strength-based approach meant that we had to accept that people had the right to take risks and that we had to ensure our approach supported them to do so. As a result we ensured we were challenging our own processes and thinking, making sure it did not get in the way. For example, being more flexible in our approach to what people could use Direct Budgets for and shifting our focus to helping people achieve what mattered most to them.

e) Empowering individuals and staff to do the right thing

The lessons learnt from the many initiatives that Stronger Together Thurrock was responsible for, were that if people were empowered they would achieve better results. We learnt that it was essential to free professionals from much of the bureaucracy and hierarchy that often got in the way of moving from process-focus to outcome-focus, freeing them to use their time to greater effect. An essential part of this was adopting a place-based approach, locating teams in the part of the Borough they were working. Staff needed to be provided with the autonomy to do the right thing and trusted to make common sense decisions. Where we tested this, it resulted in very positive evaluation reports with numerous case studies demonstrating how the approach could result in people achieving better outcomes with the need for service intervention lessened.

At the same time, we were able to demonstrate the value of non-service solutions and community assets. This undoubtedly helped to support a case for change focused on moving away from services and towards a broader solutions-based process to delivering outcomes.

f) Shifting power away from organisations to people

What we learnt from our work with Stronger Together was that organisations did not hold all of the answers. The balance of power was in favour of the organisation – the organisation decided who was 'eligible' and when they were eligible, what service someone could have, and what response someone would receive if they had a specific condition or need. Performance and regulatory regimes reinforced how organisations operated – with both Health and Social Care having to report nationally on performance indicators that had no bearing on whether outcomes were being achieved and were often focused on process.

Asking people what was important to them and how they could best achieve it with our support, resulted in solutions that came nowhere near 'service-land', or as a minimum started to challenge the embedded reliance on a service being seen as the only solution to a problem.

The realisation that health and care practice had disempowered both staff and people requiring our support, led to key changes being made. For example, the introduction of strength-based social work completely changed our social work assessment, developing an outcome-based approach that enabled social workers to find solutions that were broader than existing services and bespoke to the individual. This was seen as best practice and included in the Chief Social Worker for England's Annual Report on more than one occasion. The creation of and use of an asset map developed by Stronger Together Thurrock was key to this shift as was the development and delivery of a culture change programme for social work staff.

The view that power has to shift from organisations and professionals to people and communities has continued to help drive and inspire transformation in Thurrock.

g) Shifting away from crisis: the importance of investment and focus in early intervention and prevention

Our early transformation work helped us to demonstrate the importance of investing in prevention and early intervention. With the onset of austerity, many local authorities had a tendency to make savings via the 'salami slicing' of services rather than rethinking how outcomes could be met differently.

The pressure on us to take the same approach was significant, however we managed to resist by recognising that the solution to meeting increasing demand and reducing resource was not going to be a reduced service offer, but a different one.

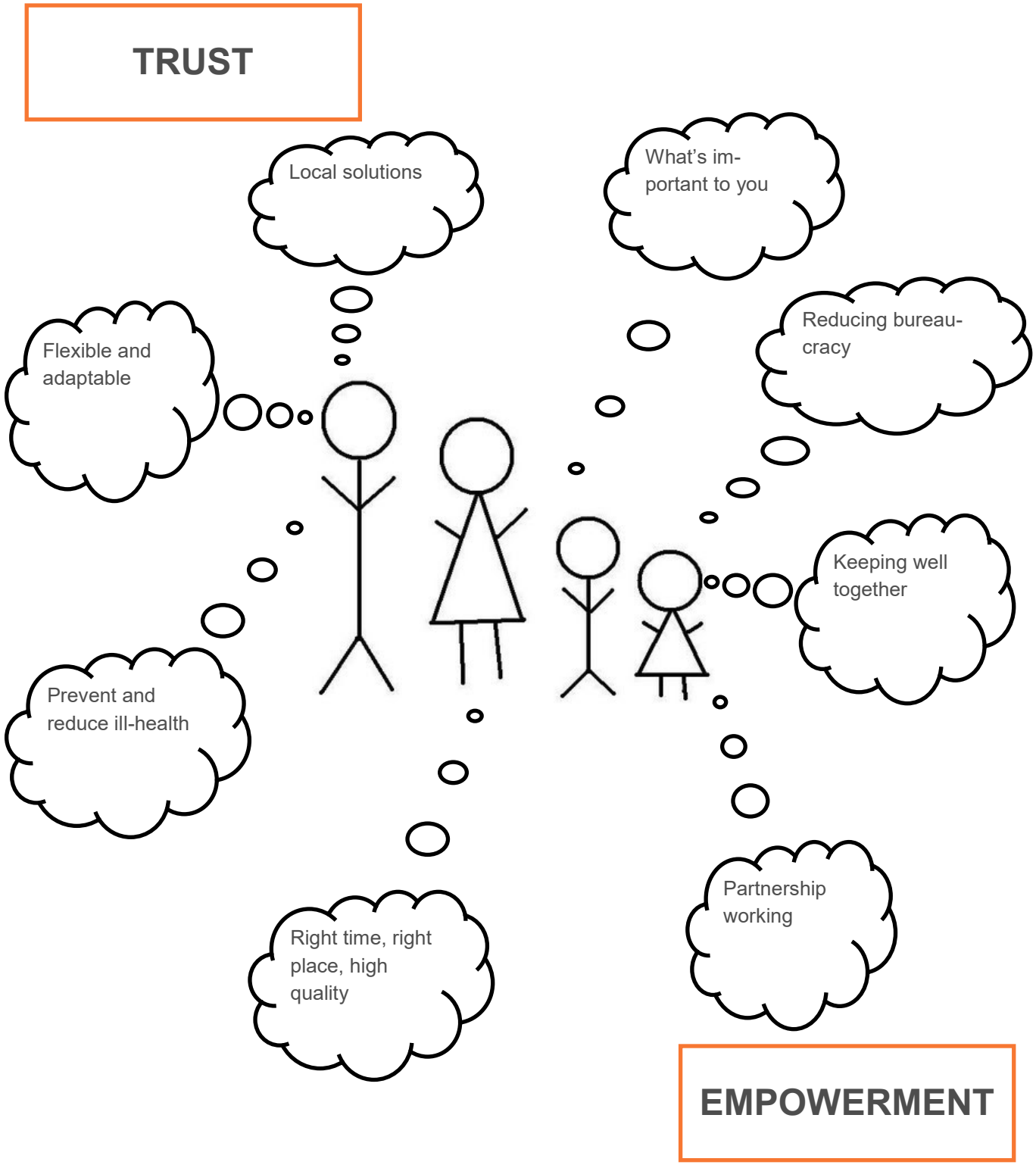
Pooling Health and Social Care budgets through the Better Care Fund, the shifting to the Local Authority of the Public Health Grant, and the Stronger Together Thurrock partnership allowed us to innovate. It also enabled us to define 'resource' in terms of the assets communities and individuals had to offer rather than just the services provided by or commissioned through statutory organisations. Our first point of contact (Thurrock First) for example knew what was happening in communities and services so that they could offer more rounded information and advice and provide solutions at first point of contact.

This thinking allowed us to expand the market place – for example through the development of micro enterprises with the conversion of one post to support this work. The thinking also allowed us to invest in and support what communities could offer – for example supporting the development of community hubs and supporting and enabling the development of community assets.

The transfer of Public Health responsibilities from the NHS to Local Authorities supported us in our belief that investment in early intervention and prevention was key – as was influencing the wider determinants of health and wellbeing. The Public Health Grant also supported Adult Social Care with some of the investment required – for example supporting the expansion of Local Area Coordination.

Developing a clear set of principles—describing the future state

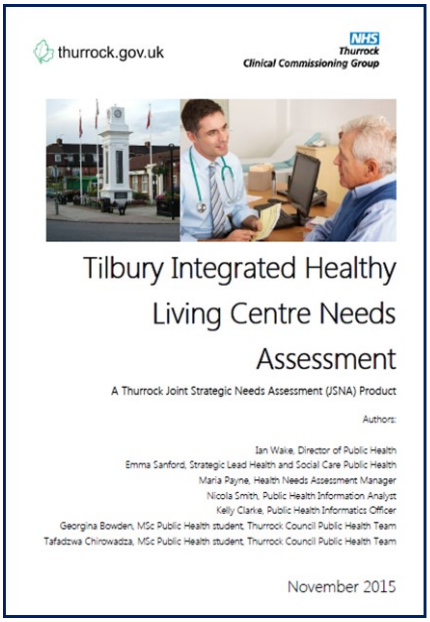
The first phase of transformation locally consisted of a number of initiatives and approaches. Not all of them were linked together, and many were the result of opportunities rather than careful planning. When reviewing what we had achieved through Building Positive Futures and considering what we needed to learn for the future, a clear set of principles started to emerge. Whilst the principles have continued to be refined, they remain at the heart of our transformation approach to date and have been co-designed with Thurrock citizens.

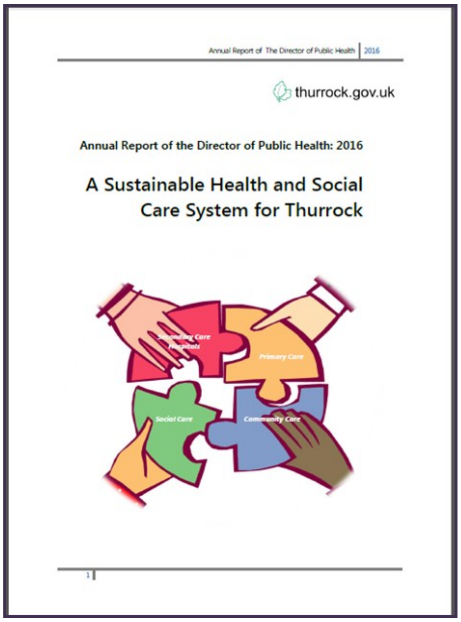


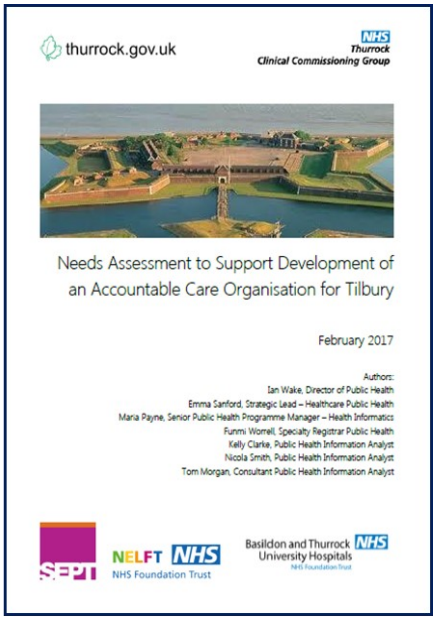
ENTERING A NEW PHASE—A 'CASE FOR CHANGE'

In 2015 a new Director of Public Health (DPH) was appointed. His vision for change aligned with our principles of system change. He recognised that the current system was broken and that rearranging the deckchairs would not deliver a sustainable solution. He also recognised the importance of prevention and early intervention and influencing the factors that would stop people from having to reach crisis point before an intervention was put in place.

Thurrock had a number of system issues that were exacerbated in some areas of the Borough in particular. For example, having some of the most under-doctored areas in the Country; and attendances at Accident and Emergency being far higher than necessary. As a consequence, the DPH focused his Annual Report on 'System Sustainability'. Following this, in 2017 the DPH published his **Case for Change: A New Model of Care for Tilbury and Chadwell**. This would drive forward our new integrated transformation approach.







The DPH published a number of key documents helping to shape plans for system redesign.

Key findings and recommendations

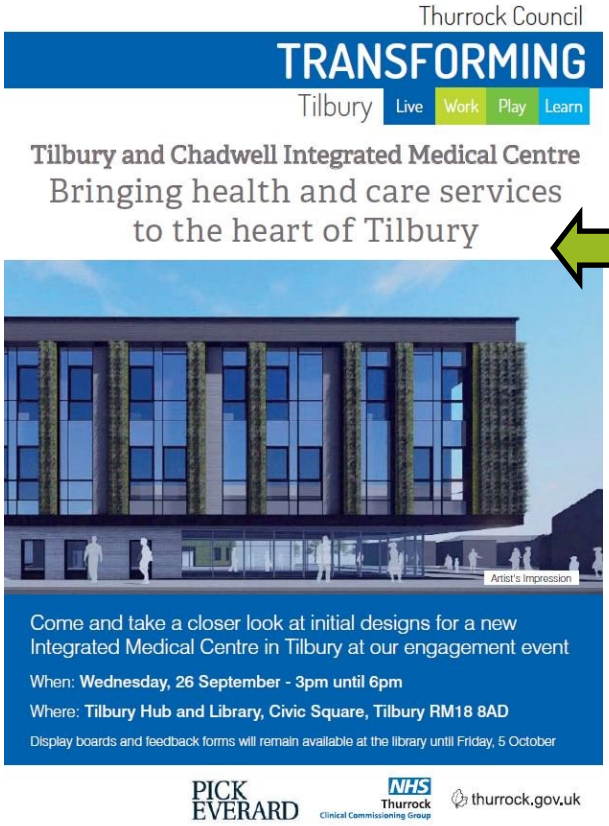
⇒ Funding and patients were in the wrong part of the system (Acute) with the system set to react to crisis and a need to shift demand from the 'acute' end and 'upstream' to the community;

⇒ Inadequate capacity in Primary Care was contributing to inadequate quality (and increased pressure on the rest of the system) meaning that people with Long Term Conditions were potentially not being identified and managed and that a priority for system redesign should include increasing capacity in Primary Care, Community Health Care and Adult Social Care;

⇒ Solving the capacity and quality issues would mean that money would be freed up; and

⇒ Solving the quality issues would mean integrating the system – and the money.

Primary Care Capacity—introducing Integrated Medical Centres



Four Integrated Medical Centres planned for the Borough offering a mixture of health and social care services along with community space.

Shifting non-acute hospital services in to the community and close to home.

At the same time as the DPH was writing his report and considering how to 'fix' the challenges to the system, work was taking place to improve the capacity of Primary Care.

Plans for the introduction of four Integrated Medical Centres (IMC) across the Borough and mixed-still Primary Care Networks were agreed. Thurrock would be divided in to four areas of approximately 40,000 population per area (consistent with the NHS Long Term Plan and Thurrock's desire to move to Place-based working). Plans would include moving some secondary care services from Orsett Hospital to communities—based within the four IMCs. A commitment was made to deliver the first IMC in Tilbury and Chadwell. Tilbury and Chadwell became our innovation area for Health and Social Care redesign and signified a step-change towards place-based and population-focused system working. GPs across Thurrock agreed to pool their £3 per head transformation monies for the purpose of testing the mixed-skills workforce in the innovation area Primary Care was a key partner and essential to successful redesign.

Developing a ‘blue print’ for system redesign

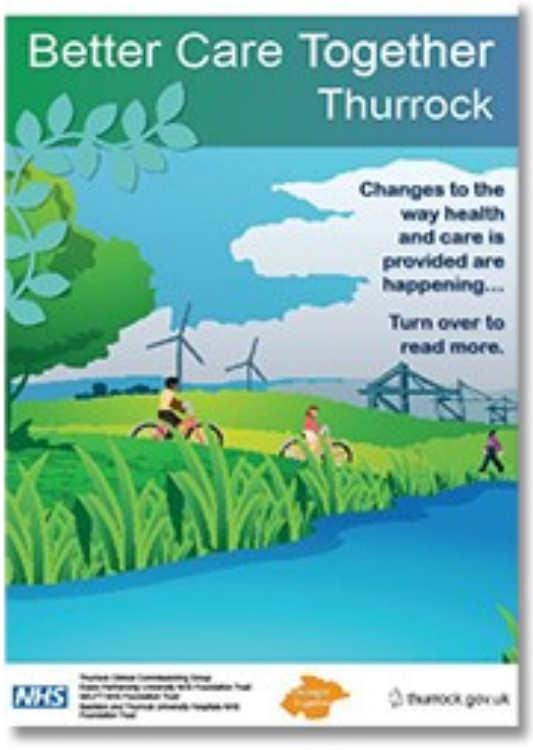
Better Care Together Thurrock

A commitment to addressing the Primary Care issues in Tilbury and Chadwell gave the DPH an opportunity to introduce a ‘case for change’ and test some of the recommendations made in his Annual Report on ‘System Sustainability’. The fact that the DPH was able to straddle both health and local authority worlds meant that he was able to garner support from clinicians and health professionals along with colleagues in social care. Tilbury and Chadwell would act as an innovation site and develop the blue print for the future health and social care system. As part of this and in addition to the Annual Report, the DPH commissioned his team to produce a Joint Strategic Needs Assessment focusing on Tilbury and Chadwell. This helped to shine a light on the issues that the new system would need to address and would ensure that it was tailored to

Developing Whole System Redesign

The work carried out by the DPH alongside the pressure on Health and Social Care to find solutions to the challenges being faced without significant additional funding being made available brought partners closer together and introduced a new phase of transformation called **Better Care Together Thurrock.**

Better Care Together Thurrock (BCTT) consisted of senior partners from Adult Social Care, the Voluntary and Community Sector (CVS), Community Health (NELFT NHS Foundation Trust), Mental Health (Essex Partnership University NHS Foundation Trust—EPUT), the Acute Trust, (Mid, Southend and Thurrock Hospitals NHS Trust) the CCG (NHS Thurrock CCG), and Primary Care. It was paramount that any change was co-designed with communities themselves, and they were also seen as an essential element of the partnership. The majority of these partners had already worked together to develop and deliver an integrated Single Point of Access (Thurrock First) covering Mental Health, Community Health and Adult Social Care.



Integrated Governance—Thurrock Integrated Care Alliance (TICA)

Our aim to develop and deliver a population health and care system that focused on place relied on building strong partnership arrangements with a range of partners - both statutory and non-statutory. This meant partners had to be able to define and agree a set of desired health and wellbeing outcomes and to commit to working collaboratively to ensure that those outcomes were delivered.

As a result, Thurrock health and care system partners developed an Integrated Care Alliance known as Thurrock Integrated Care Alliance (TICA).

The operation of the Alliance was set out in a Memorandum of Understanding that all system partners signed up to.

Alliance Objectives

1. Reducing the number of unplanned hospital and residential admissions

2. Reducing the number of A&E attendances for conditions that could have been treated elsewhere within the community

3. Reducing the number of Delayed Transfers of Care

4. Keeping people as independent as possible for as long as possible, and reduce/prevent/delay entry into care and support services

5. Moving more services out of hospital/acute care into the community

Pledge to the local people

- You are less isolated and have the opportunity to be well connected where you live;
- You are able to get the majority of the support you need from within your neighbourhood and as a result you access health and care services less frequently;
- You are enabled to live a healthy and happy life based on the quality of support that you receive;
- Our health and care system treats you as an individual and does not define you by your illness or condition;
- You can get the physical and mental health support and care you need at the right place and at the right time;
- By bringing health and social care services and resources together we will reduce duplication, improve efficiency and provide a better response;
- We act before you reach crisis point and reduce the number of times you need emergency health or care services.

An integrated vision for health and social care

A key first step was for partners to agree on and articulate the vision for the future health and care system. This was agreed at a Theory of Change workshop hosted by Thurrock Community and Voluntary Sector and Thurrock Coalition, our user-led consortium

Our Vision

To provide better outcomes for individuals that are closer to home, holistic and that create efficiencies (by shifting re-sources to deliver a better impact) within the Health and Care system

What is the impact that people want to see from system?

Communities told us that they wanted to see the following:

1	I am less isolated and have the opportunity to be well connected where I live
2	I am able to get the majority of support I need from within my neighbourhood
3	The health and care system treats me as an individual and does not define me by my illness or conditions
4	I will take responsibility for staying as healthy as possible and take responsibility for using health and care resources appropriately and responsibly
5	I can get the support and care I need at the right place and the right time
6	By bringing health and social care services together there is less duplication,
7	Health and Social Care providers act before I reach crisis point
8	I am enabled to live a healthy and happy life

Better Care Together—Redesigning Health and Social Care in Thurrock

Following the Theory of Change workshop, partners worked to identify how best to deliver the required change and impact. Building on the work carried out by the DPH and on previous transformation work, four clear work streams were identified for Better Care Together.

1. **Identification and Management of Long Term Conditions**
2. **Building Capacity and Capability in Primary Care**
3. **Developing Strong and Resilient Communities**
4. **Transforming Community Services**

Mental Health Transformation

In addition to Better Care Together, but working to the same aims, is Thurrock's Mental Health Transformation Programme.

Communication and Engagement

All partners are involved in and have contributed to the establishment of an integrated Communication and Engagement Group

Identification and Management of Long Term Conditions

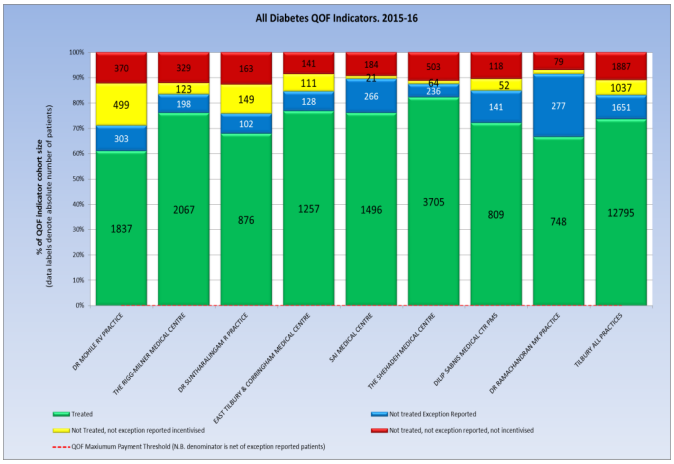
Analysis carried out by the Public Health Team identified significant variation in the identification and management of people with long term conditions by GPs in the innovation area. The term 'find the missing thousands, treat the missing hundreds' was coined. The Team concluded that based on estimated prevalence, there were significantly more patients with conditions that had not been identified.

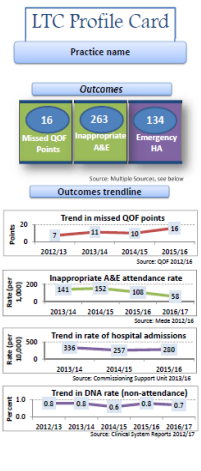
Using the Public Health Grant and Better Care Fund, a programme of work was established to identify and test how Long Term Conditions could be better identified and managed. This included funding a 'stretched QoF' to ensure that GPs in the innovation area were identifying 100% of patients with Long Term Conditions; case finding to identify patients with conditions not captured on registers; and score cards for GPs to help them self-manage the areas that were not performing as well as they should.

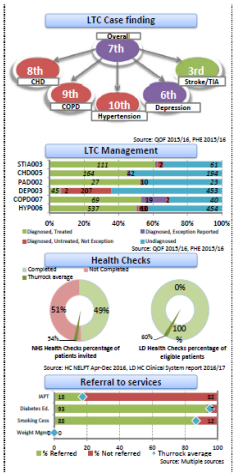
➡ **Finding and treating 100 undiagnosed residents with high blood pressure will prevent 10 strokes over three years**.

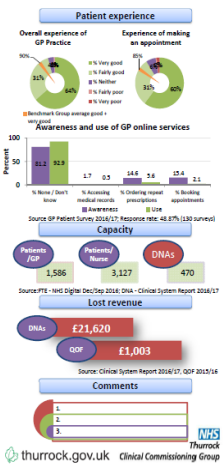
➡ **10% increase in register completeness would equate to 270 avoidable strokes and a £1.8m saving in avoidable cost.**

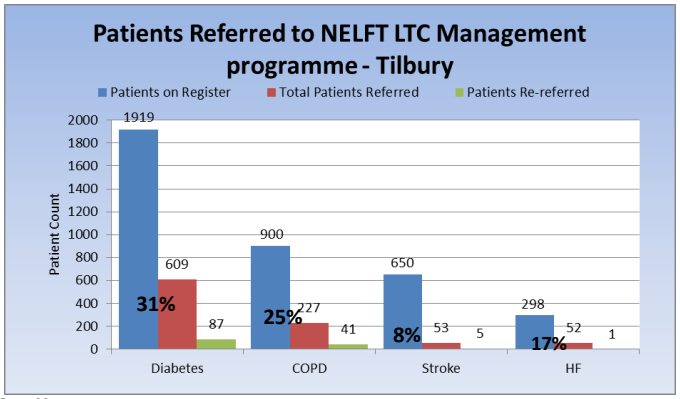
6. Find the missing thousands, treat the missing hundreds











- Stretched QOF
- LTC Management Card Roll Out
- Mede-analytics highlight patients requiring review
- Centralised call-recall
- Integrating LTC Community Management with Enhanced Primary Care Team
- Include IAPT
- Increased LTC nursing capacity investment from PHG

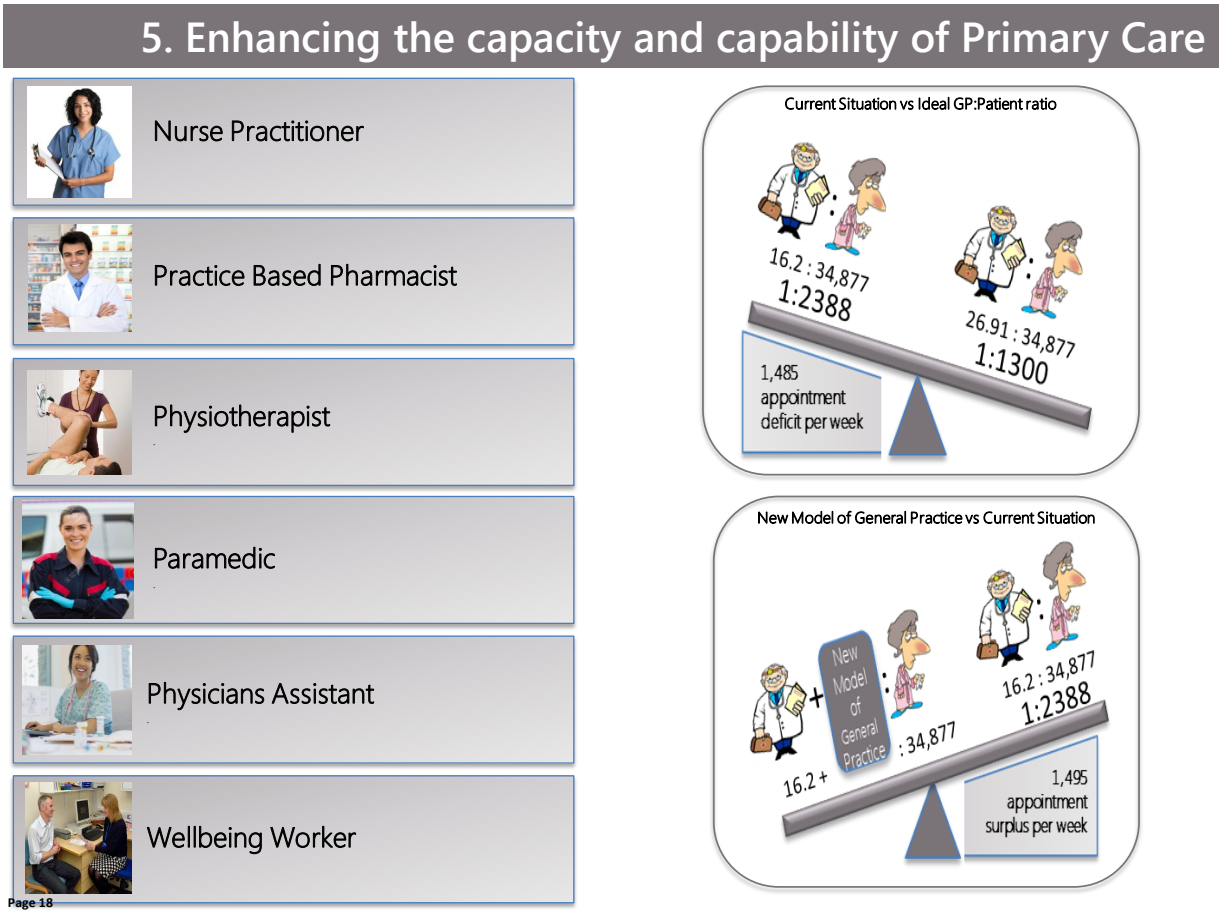
Enhancing the capability and capacity of Primary Care

Thurrock had significant capacity issues – particularly in the chosen innovation area. Analysis showed that 91.6% of patients using Primary Care were 'mainly healthy' and that this group of people needed to be able to have timely access to appropriate Primary Care, Healthy Lifestyle Services, and a focus on tackling the wider determinants of health and wellbeing.

Analysis also showed there had been a 15% increase in demand over the last four years, that the length of appointments were not adequate, and that as a result, **9 out of 10 patients in the innovation area attending Accident and Emergency were avoidable**.

Research showed that for every 1% increase in the availability of appointments in Thurrock, 6543 emergency hospital admissions for COPD and 109 emergency hospital admissions could be avoided – resulting in a £2.9m saving to the NHS alone.

Thurrock's response was to develop a pilot mixed skills team with GPs across Tilbury and Chadwell. To ensure that more people could access Primary Care. A number of posts were employed to work as part of the mixed-skills team.



Transforming Community Services

Achieving BCT Thurrock's vision and outcomes meant redesigning what was offered by health and social care in the community and how it was offered. The principles underpinning our transformation approach emphasised the importance of using a strength-based approach and ensuring a focus on outcomes. We also wanted to bring professionals together to reduce duplication. This meant looking beyond traditional services to find solutions when people required support. It also meant focusing on issues essential to achieving good wellbeing such as reducing isolation and loneliness. The importance of 'place' had grown in priority over the course of our transformation journey, and this was fundamental to how we changed our approach to service delivery.

Changing Domiciliary Care

The fragility of the current care market coupled with growth in demand has become the greatest threat to our ability to meet demand for care. This was placing pressure on the entire system. We knew that just providing more of the current model of domiciliary care would not help to alleviate overall system pressures or to help people to achieve the things that were important to them. We started to look at new models – models that were consistent with the principles underpinning system transformation.

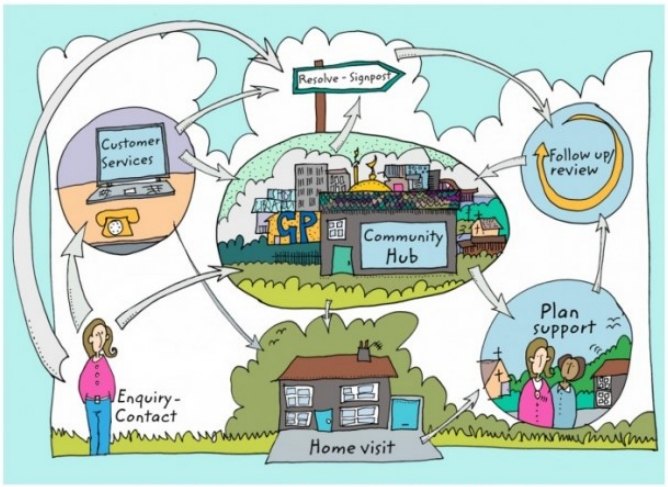
The **Buurtzorg** approach was an attractive proposition that we investigated. Founded in Holland, the model promoted small self-managed teams and focused on team members being freed up to spend more time with the people they were supporting – but with an emphasis on finding out what mattered to the person they were supporting and helping them to achieve the things that mattered most to them. Back office functions were provided by a separate entity. There were numerous examples of increased efficiency and of improved outcomes for people being supported. The concern for us was that Buurtzorg approach had been tried and tested on nursing teams and not on domiciliary care.

Wellbeing Teams had recently been launched by Helen Sanderson Associates. The model used a Buurtzorg approach but was applied to a domiciliary care setting. Wellbeing Teams used small self-managed teams covering small geographical areas. The Teams built a Wellbeing Plan with the individual being supported. The Plan articulated what mattered to the person and how that could be achieved – which would be under constant review. The Plan also focused on how other people in the person's life could help, how community assets could be utilised, and also looked at technological solutions. A service solution was considered last after all other options had been exhausted. The aim of the approach was to move away from time and task (allocated hours would be used flexibly) and to address the care workforce drought by providing a salaried post, removing split shifts, providing career opportunities, and enabling staff to be empowered. Thurrock is trialling two teams.

Community-Led Support

Approximately 80% of social worker time is spent on tasks that are not face-to-face. Wanting to challenge and reduce bureaucracy and remodel how social work operated around and within a place, we commissioned the National Development Team for Inclusion to support us to deliver their Community-Led Support programme within our health and social care innovation area.

We launched a pilot Community-Led Support Social Work team in October 2018. The Team has been able to take strength and place-based working further as well as challenge and change existing practice. Through running drop-in sessions (known as 'talking shops'), the team has improved social work access and has also been able to identify people needing support or likely to need support. Offering appointments in the community rather than always default to home appointments has also enabled people to discuss their situation in a neutral location and has enabled the social worker to see how well the person is able to get around and what their support network is. Through the work that has taken place by the team to get to know the community, the number of actual assessments has also reduced as a result of the team being able to provide informal solutions where they would have previously provided a service.



Working in a community has also provided other benefits. The CLS team has been able to secure good working links with other statutory services, for example local enhanced Primary Care Team, pharmacists, Housing Estates Team. It has also freed up time by reducing mileage and the time taken for appointments – particularly when individuals are able to come to an appointment at a community venue. The Team has also been able to review and revise the assessment approach and has been given the freedom to make decisions.

Thurrock Community-Led Support Team—Tilbury and Chadwell

The success of 'phase 1' has led to a decision being made that all of Thurrock's Adult Social Work teams will adopt a CLS approach—by April 2020.

Technology Enabled Care

Our aim was to embed Technology Enabled Care in all we did – whether it was a strength-based conversation between our Local Area Coordinator and a resident seeking advice or part of a formal assessment. In other words we wanted to be much more tech-savvy and harness the power and potential of technology enabled care.

The approach includes representatives of adult social care, housing, the voluntary sector, health, public health, libraries and College Health.

The aims of the project are:

- ⇒ Raise community awareness of the possible applications of all technology
- ⇒ Encourage the take-up of appropriate technology enabled care to support vulnerable people to be safe, independent and connected both within their homes and outside
- ⇒ Support carers through greater use of technology enabled care
- ⇒ Combat loneliness through connecting isolated people to the wider community and family and friends
- ⇒ Encourage greater digital health literacy
- ⇒ Prevent, reduce or delay the need for social care or acute health interventions

Our first priority was to raise awareness of what technology enabled care could offer. We wanted our staff – most of whom live in Thurrock, to be TEC champions: if their family member or a neighbour could benefit from technology enabled care, they would be able to identify potential technology solutions (or indeed a non-technology solution) and secondly, know who to contact to take it to the next step. Training has been arranged to enable this to take place and staff from a range of partner organisations, community organisations and individual volunteers are included.

In parallel we are training up a smaller group of people to have a high level of expertise and who can carry out complex telecare assessments.

We have already started to implement and test some early initiatives as well as building TEC considerations within our approach to identifying health and care solutions that help people to achieve what is most important to them:

Residential Care—We have begun a telehealth pilot project at the Council's residential care home Collins House with the support of Docobo telehealth portals.

Phone Applications - We are trying out a phone app that has been developed to support younger people and working age adults with anxiety and depression called 'Brain in Hand'. The app. helps people navigate daily life with a suite of instant problem solving suggestions for events that can cause major anxiety or even prevent people leading an independent life. We are trialling the app. with 10 people.

Thurrock ‘App Wheel’

Designed by Thurrock Coalition for Wellbeing Teams

Market Development

The development and diversification of the market place is fundamental to our ability to succeed and to the extent of our success. Developing and shaping the Market Place is being taken forward through Better Care Together. An example of how this is taking place is through the introduction of Micro Enterprises. With over a 100 Micro Enterprises now in place, Micros broaden the market 'offer' so that people are able to find solutions that help them achieve what's important to them - rather than responding to their immediate health or care needs.

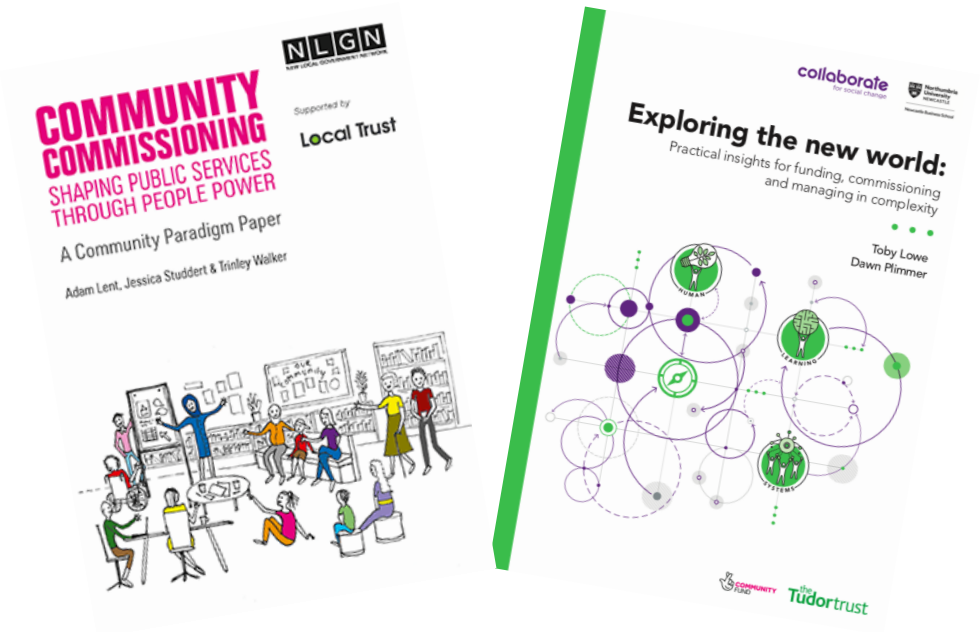
We are developing the existing market offer through our work to reshape how we provide care in the home. The provision of homecare in Thurrock has predominantly been carried out by large providers, contracted on a time and task and £ per hour basis. The introduction of the Wellbeing Teams pilot paves the way for a different type of delivery model and a different approach to commissioning – one that encourages and promotes small local franchised businesses focused on the delivery of outcomes personal to the individual.

We are redefining Thurrock's 'market place'. Through our work with Stronger Together, the market place has expanded to include grass roots business and a market that is tailored to and responsive to place.

Health partners too have recognised the importance of giving key NHS providers the space to take responsibility and control for system and service redesign—working together as partners (Integrated Care Alliance). One of the decisions that has helped achieve this was the decision to extend NHS provider contracts to 5 years. This allows the time and space for providers to invest in redesign and in the local community and for different commissioner/provider relationships to be build..

The redesign of commissioning and the shaping of the market place will continue through the next phase of Better Care Together.

A number of 'think tanks' are looking at how commissioning across the health and care system needs to change



Community Resilience (Stronger Together Thurrock)

The work carried out through the establishment of Stronger Together Thurrock in 2011 highlighted the importance of community resilience, social justice and social capital in establishing and maintaining good health and wellbeing and to the prevention agenda. Through Local Area Coordination, we were seeing the power of the community in providing their own solutions and helping people to achieve outcomes that services alone could never have delivered.

The power of communities and their ability to provide solutions that services and organisations could not and should not try to replicate has been a key driver in the way our transformation programme has developed. This has included a focus on place, outcomes, strengths and helped to shift away from a focus on need, conditions and organisational silos.

Our transformation programme recognises that success cannot be achieved by waiting for people to require a service and must drive a shift in power and control from 'the system' and to 'the people'. Continuing to support and grow our Stronger Together programme aims to ensure this can happen – but also highlights the investment needed in the community to enable a thriving community infrastructure to exist. This is something often ignored, leading to a breakdown in trust between the third sector and statutory organisations, with the criticism of 'asset stripping' levied against them.

One of six Community Hubs in Thurrock—acting as connecting points, places where people can get information and advice, and empowering communities and individuals.

Time Bank—a way of people sharing the gifts they have with others and either banking the time they give for others to use, or being able to use it themselves

Social Prescribing in Thurrock commissioned by Thurrock CCG and hosted by Thurrock CVS

Thurrock Social Prescribing
A Project of Thurrock CVS

Funded by the Better Care Fund, By Your Side supports people to settle home when the leave hospital.

BYS Volunteering
By Your Side A project of Thurrock CVS

The Impact of Our Approach

Whilst evidence of the difference we have made may be seen and felt over a longer period of time, we have already begun to see the positive impact of the approach we have taken. Some of this is due to the work we began as part of Better Care Together – where we have been able to scale-up schemes started some time ago, or introduce new initiatives based upon our learning from previous transformative phases.

Challenging existing methods of measuring performance

Our approach to transformation has challenged the way we measure and evaluate the perceived success of our system. This has traditionally been driven by measures that focus on how well the process works – e.g. how many assessments have taken place, breaches of the four-hour wait etc. Most measures and evaluation techniques focus in the main on quantitative data – often missing the value of stories and case studies in proving how well a service was or was not working and whether it actually helped someone to achieve a 'good life'. This approach in the main is driven nationally, but has shaped how statutory services think about 'success'.

Our approach throughout our transformation journey has been to develop evaluation frameworks and performance measures that are meaningful – both in how we capture the impact on the system of the changes we are making, but most importantly capturing the difference we make to the lives of the people we support. For example, the Buurtzorg model has one key performance measure – the amount of time spent face-to-face with people requiring support. We have maintained throughout our work that 'doing the right thing' is often the most cost effective course of action. Evidencing that this is the case may help to transform national expectations of what is measured and how it is measured, and will also help to transform how we commission and contract manage – which should be a framework that focuses on outcomes. We are working with regional colleagues to develop this agenda.

Not everything that can be counted counts….

Not everything that counts can be counted...

I'm on the Tilbury Wellbeing Team and we visit a lady who hasn't been out of her flat and into town in 2 years as her wheelchair wasn't working. As a Team we got her wheelchair repaired and took her into town and into the bakers for a currant bun. This was really lovely for the lady we were supporting and for me to see the difference in her mood. We have since done this again and she looks forward to the little trips out even if it's for 10 minutes round the block.

Successes

We have had a number of successes with our programme to date and hope to build on these as we move forward.

a) Integration

- Achieving an integrated approach to health and social care transformation (Better Care Together), including vision, outcomes and partnership arrangements across both providers and commissioners
- Integrated Single Point of Access – Thurrock First – which included an integrated budget, management and staff
- Integrated Community Team—providing an integrated health approach to people who are housebound

b) Partnership Working

- Working in trust-based collaboration across health, social care and the third sector—for example Stronger Together
- The development of close working relationships with the community – who are an equal partner

c) Community Resilience

A history of supporting communities to be resilient and self-supporting through Stronger Together Thurrock which has included successful initiatives such as:

- Local Area Coordination - 14 Local Area Coordinators now in place
- Community Hubs – 6 in place
- Time banking – several thousand hours banked
- Social Prescribing – rolled out to practices across Thurrock
- Asset Based Community Development – empowering communities to develop and share strengths
- Micro Enterprises – now over 100 in place providing real choice to people requiring some support to maintain a good life, and also giving local people employment and volunteering opportunities
- Collaborative Communities—a Council-led programme designed to shift more control to communities as to how services are provided and who provides them

d) Built Environment

- Recognising and maximising the value of the built environment – securing funding and investment to develop Housing Ageing Population Panel for Innovation (HAPPI) schemes for people as they grow older, developing specialist housing to provide options for greater independence for adults of working age and to reduce reliance on residential or out of borough placements
- The development of the Housing and Planning Advisory Group – a partnership between Health, Police, Social Care, Housing, Planning and Regeneration to positively influence the built environment and to take account of future health and care needs (for example via the Local Plan)
- Residential Care for the 21st Century – plans for a new residential care facility that will help meet future demand and will better deliver on tailoring to individual outcomes.

e) Prevention and Early Intervention

- Numerous examples of how Local Area Coordinators have worked with individuals to reduce service packages, reduce crisis, avoid the need for a service package, and help the individual to reengage with their community
- Numerous examples of how our Community-Led Support Team have identified individuals requiring care and support at an earlier opportunity, how they have provided community based solutions rather than service solutions, and how they have reduce the need for care assessments as a result
- The Stronger Together Thurrock approach – which has significant examples of how community resilience has been built and how as a result people have been connected within their communities and key issues for health and care such as loneliness and isolation have been reduced
- 'Find the missing thousands, treat the missing hundreds' – Public Health analysis identified that a 10% increase in disease registers would lead to 270 avoidable stokes in the innovation area over three years, leading to a system saving of £1.8m. Early work funded by the Better Care Fund included a stretched LTC identification and management QoF for GPs (QoF threshold 80% which the investment stretched to 100%). 24 surgeries signed up to the initiative, and in the first three months 1684 additional patients were identified
- 9 out of 10 people from the redesign innovation area attending Accident and Emergency did not need to attend. Some of this was as a result of significant under-doctoring. Enhanced Primary Care networks that include a range of clinical posts in the innovation area have turned an appointment deficit in to an appointment surplus. This is already being seen to have an impact on hospital attendances.

f) Strength-based Social Work

Our approach has resulted in considerable recognition – including a case study in the Chief Social Worker for England's annual report two years running. We have taken this model further through the implementation of Community Led Support. The Team has no base but is located within the community it serves. The approach has led to a number of successes:

- **Strengthening strength-based working** – the Team has redesigned the way it works so that it can focus far more on conversations with people to help them identify and achieve the things that matter most to them – e.g. through a refined assessment. The Team's increased knowledge of what is available within the community has helped to be able to provide individuals with a broader range of solutions and has reduced service reliance.

- **Reducing bureaucracy** – the Team has redesigned and reduced existing processes including the way they assess and commission packages of care. They are now spending approximately 60% of their time carrying out face-to-face contact—originally approximately 20%.

- **Increasing time available to spend with individuals** – through reducing bureaucracy, reducing travel time, holding drop in sessions and also inviting people to see them in the community rather than home visits.

- **Increasing non-service solutions** – through being based in the community, the Team has been able to build up significant knowledge of what is available so that their ability to offer non-service solutions has increased. In addition, through the operation of drop-in sessions, the team are picking up people at an earlier opportunity with means that they are catching people before they are at the stage where a service solution is required.

- **Distributive leadership** – the Team has been empowered to make decisions as it sees fit – 'don't break the bank' and 'don't break the law' being guiding principles! This has led to the Team feeling empowered and making changes without seeking permission.

- **Integration** – working on the ground, the Team has been able to make links with other teams across health, social care, the council and the community. This has led to the organic development of an integrated health and care system – e.g. working alongside housing colleagues, Wellbeing Teams, Local Area Coordination, Enhanced Primary Care Networks. This has enabled integrated visits and appointments, integrated solutions, and integrated working around a place.

- **Place-based approach** – the delivery of social work in a place has tested and advanced the concept of place-based working which has acted as a forerunner for other initiatives. The success of CLS has now led to the approach being rolled out across Thurrock.

g) New Models of Care

Whilst by no means complete, we have been able to develop and deliver a number of new models of care. This is fundamental to the successful transformation of Health and Social Care as the problem will not be solved with the same thinking that created it. Examples include:

- **Wellbeing Teams** – two pilots in place to test an alternative model to our existing domiciliary care model. Wellbeing Teams tests a number of new approaches and aims to address a number of existing challenges that include recruitment and retention, professionalising the care industry, focusing on delivering outcomes, and moving away from time and task;
- **Open Dialogue** – a model which applies a family therapy solutions-based approach to managing residents in Mental Health crisis. This responds to a Mental Health JSNA produced by Public Health and a Peer Review carried out in June 2018. It will form the basis of Mental Health transformation;
- **Self-Directed Occupational Health** – following engagement with Thurrock's user-led coalition 'Thurrock Coalition' and a risk assessment, we have developed a self-directed Occupational Health assessment. The assessment is strengths-based and through its use, approximately 50% of self-identified solutions have been delivered without the need for a professional-led assessment.
- **Enhanced Primary Care Teams**—we have recruited 16 primary care professionals to work with our Tilbury and Chadwell Primary Care Network and also our Grays Primary Care Network. The skills mix aims to ensure that people see the right person first time; aims to reduce onward referrals; and aims to close the appointment deficit in under-doctored practices and areas.

h) Market Development

The market has to develop to be able to respond to the changes being made to the health and social care system. Thurrock has worked proactively to introduce a broader market that means people have greater choice and are able to find providers that help them to achieve their out-comes and not just meet their care needs. This includes both people who are 'eligible' for care under the Care Act, and those that identify that they need some support – or that we identify as needing support as part of a preventative measure. The success we have had, whilst continuing to develop the market includes:

- An alternative delivery model for domiciliary care (Wellbeing Teams – see earlier section).
- Micro Enterprises – with over 100 now in place, micro enterprises have provided significant variety for people in Thurrock needing some support. These range from pet sitting, gardening, handyperson, and taxi services to more specialised home care businesses. The businesses have also provided flexible opportunities for Thurrock people wishing to work or volunteer.
- Asset Based Community Development – an approach focusing on identifying, recognising and utilising assets within the community as health and care solutions - helping to redefine what we mean by the 'market place'.
- Supported Living – we have commissioned the development of accommodation for adults of working age – transforming ex-sheltered housing and also using funding to build 6 bespoke properties for young adults with autism which will help to reduce expensive out of borough placements and enable people to achieve greater independent living.

A selection of our micros…….

Plates with Mates

Lunch club for older people

On Track Care Services

Support and care provision for people with autism, mental health conditions, learning and physical disabilities, sensory impairments and associated complex needs.

Fun & Fetch

Respite care for owners (hospital/care home stays etc.)

Happy Feet

Mobile foot health care service for all Thur-rock residents.

THE FUTURE—BETTER CARE TOGETHER THURROCK PHASE II

A blueprint for Thurrock

Our journey to date has helped us to develop a health and care system blueprint for the future. Whilst change is constant, there are certain elements that will be central to and continue to underpin what we do.

1. Start Small. Grow Big.

Making sure that something works and the concept is proven before scaling up.

2. Developing solid relationships

Not neglecting the importance of and time required for relationship building.

3. A focus on population and place

Adopting the principle of subsidiarity—the starting point for planning, transforming and delivering services should be at as local a level as possible (The King's Fund suggest that 70%-90% of activity should take place at a place or neighbourhood level).

4. Start with 'What's Strong'

Maintain a focus on delivering outcomes that mean something to the individual.

5. Prevention, early intervention and self-management

Focus on preventing, reducing and delaying the need for care and support, and empower individuals to self-manage conditions as they arise.

6. Distributive leadership and staff empowerment

Empower staff to do what's right and to make key decisions, removing hierarchy and making way for self-management, encouraging creativity and innovation.

7. Removing bureaucracy

Remove unnecessary process and bureaucracy to tip the balance towards face-to-face time.

8. From 'Ego' to 'Eco' ('power with the people')

Communities taking a central role in designing, influencing, and sometimes delivering what works for them. A focus on what delivers for our residents and not what is in the best interests of organisations or professionals.

9. A Diverse Market Place

Developing a diverse market that provides real choice and includes community assets.

10. Sticking like glue to agreed principles

Regardless of the model or the change, sticking to the agreed principles is a must.

So what's next?

Developing phase II—Place Based Health and Care

a) Proof of Concept

As part of the introduction of a number of new initiatives aiming to redesign the health and care system, we are evaluating both the separate initiatives and the extent to which together they are delivering system redesign. We have a number of 'success factors' identified and evaluation will measure whether the new model(s) of care are delivering against them.

We are collaborating with the University of Birmingham, NDTI, PHE and the LSE to test our approach, the outcome of which will assist us with developing and influencing phase II.

b) Scaling Up

Dependent upon the success of existing initiatives, we will aim to scale-up the innovation site model, or aspects of it, across the rest of the Borough. This may still occur in a phased approach recognising the important of community buy-in and the principle of 'starting small'. This will include:

- Implementing the mixed skills workforce across the four Primary Care Network areas of Thurrock;
- Delivery of the Community-Led Support model of Social Work across Thurrock;
- Redesign of Community Health to deliver a place-based model integrated with CLS and Wellbeing Teams;
- Roll-out of successful Long Term Conditions initiatives, for example: hypertension pilot and case finding;
- Expanding our testing of Technology Enabled Care; and
- Expansion of self-management and consideration of expanding the Wellbeing Teams model and/or the principles of Wellbeing Team working to domiciliary care.

c) Developing our approach

There remains far more to do as we move in to phase II of our work:

- Confirmation of the place-based model for health and care – e.g. bringing together Enhanced Primary Care, CLS, Wellbeing Teams and Community Nursing to embed an integrated approach to community-based health and care;
- Development and finalisation of the business case for a new service that supports people at home – based on the outcome of the Wellbeing Teams pilot;
- Development and finalisation of Mental Health transformation and the 'Open Dialogue' pilot – future model for Mental Health and how it operates within the community-based health an care system;
- Community-led commissioning and decision-making – developing pilots and initiatives that test approaches and providing locality budgets;
- Integrated commissioning and provision – developing and testing where it makes sense to integrate;
- Continued development of how technological solutions can be applied to a variety of situations;
- Development of the Wellbeing Teams model to cover non-domiciliary care elements – e.g. management of Long Term Conditions, reducing isolation and loneliness, undertaking certain health tasks, improving prevention and early intervention etc;
- Market development – linked to community-led commissioning and decision-making, developing a locality-based market development plan/position statement based on an assessment of the locality and informed/led by communities in that locality;
- A Workforce Strategy—sitting alongside our market development strategy. This includes identifying elements of the Strategy that need to be agreed and developed regionally;
- Residential Care – alternative delivery models for residential care;
- Development and agreement of governance arrangements—at a STP level, local level and neighbourhood level;
- Expanding our existing place based approach to other key elements of community and individual life – expanding across the Council and beyond towards place-based systems e.g. housing, children's services. This will be taken forward through our Collaborative Communities programme; and
- Developing and implementing the four Integrated Medical Centres which will act as Health and Care focal points for each of the four 'areas' of Thurrock.

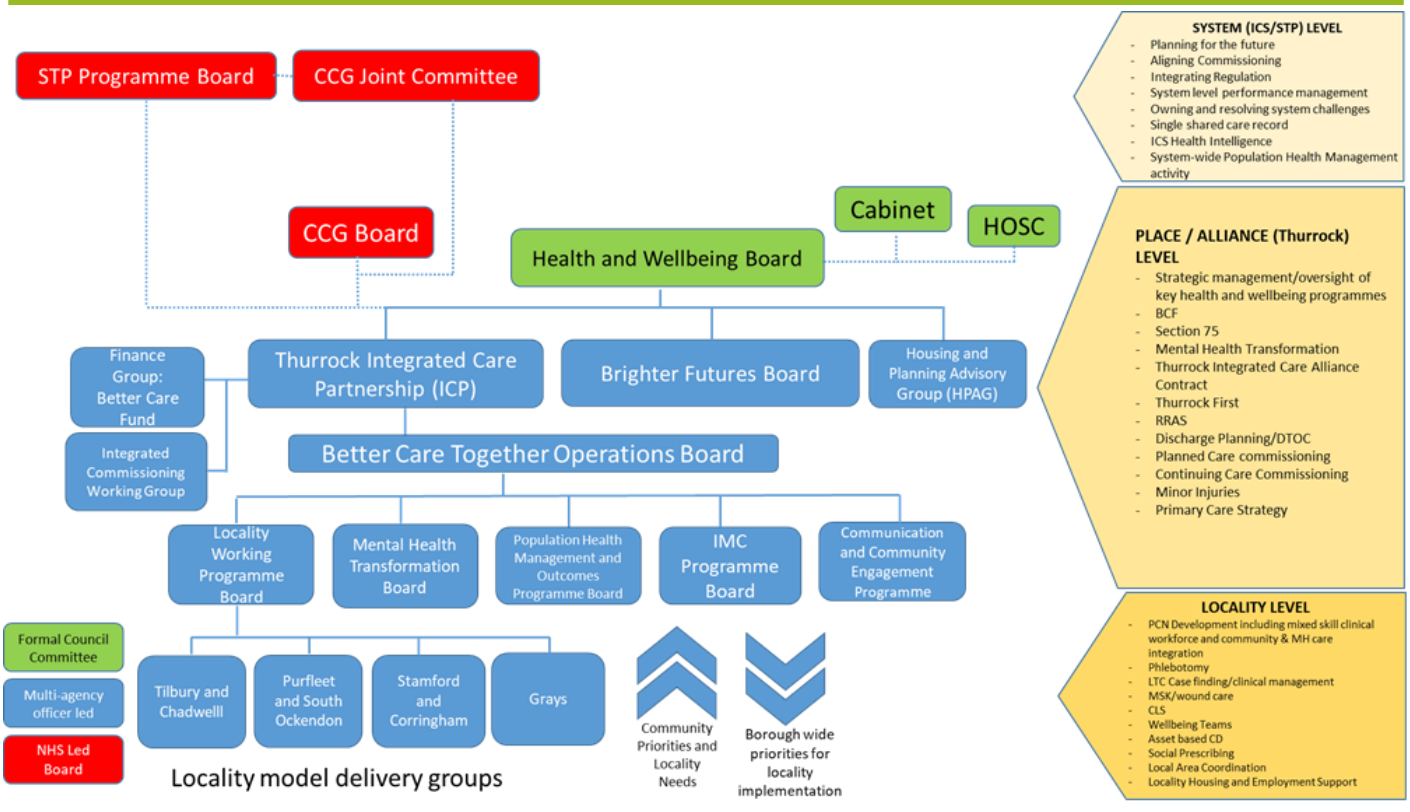
Phase II Governance—defining the roles, responsibilities and relationships of local governance arrangements

Proposals to shift NHS commissioning and system leadership responsibilities to a Sustainability and Transformation Partnership footprint has made defining and cementing local governance arrangements key. Moving decisions about Thurrock from a local system with a high level of co-terminosity and trust with partners to a complex set of partnership arrangements set over a far wider geographical footprint is a potential risk to place-based working. Whilst this is the case we recognise the benefits of some arrangements spanning a wider geographical footprint—so long as they can be influenced by and reflect Thurrock's requirements.

Thurrock Integrated Care Alliance (TICA) was established in 2018 to provide strategic direction to the local health and care system including the third sector, set shared objectives and outcomes for the system and lead the integration of commissioning. Following discussion at Thurrock Integrated Care Alliance, commissioners have awarded longer term contracts with providers. All stakeholders represented at Thurrock Integrated Care Alliance have developed and signed a Memorandum of Understanding that describes a framework within which partners will work to build a Population Health System.

The King's Fund concluded that between 70-90% of the focus of activity/integration should be at the place and neighbourhood levels with the remaining 10-30% occurring at system (STP) level.

Thurrock's Health and Wellbeing Board has agreed the governance arrangements necessary to ensure a place-based approach to heath and wellbeing, but also recognising where it is important to commission or deliver on an STP footprint. The diagram below demonstrates arrangements for Thurrock.



Phase II—Place-Based Health and Care

Phase I of Better Care Together Thurrock developed and implemented approaches to place-based working. This focused on:

⇒ Community Led Support

⇒ Wellbeing Teams

⇒ Enhanced Primary Care Teams

These new initiatives operated alongside existing place-based working developed from Building Positive Futures and Stronger Together Thurrock:

⇒ Local Area Coordination

⇒ Social Prescribing

⇒ Community resilience—Community Hubs, Time Banking, Volunteering

The next stage of our work will see us redesigning Community Health so it mirrors and develops phase I. Importantly, the community-based model for health and social care under phase II will become fully integrated.

Phase II—What's next?

The next phase of Better Care Together will consist of:

⇒ Consolidation and evaluation of phase I

⇒ Borough-wide roll-out of Community Led Support

⇒ Further development of Wellbeing Teams—developing a broader skill set

⇒ Development of a Workforce Strategy—including a regional approach where needed

⇒ The development of place-based and outcome-led commissioning

⇒ The redesign of Community Health—focused on redesigning around place and achieving integrated working

⇒ Implementation of Mental Health redesign (via Mental Health Transformation)

⇒ Expanding the principles underpinning Better Care Together to other partners and departments—in the Council via a new Collaborative Communities programme

Learning from Phase II will be documented in an updated version of this Prospectus.

Key Risks

There are a number of key risks that need to be taken in to consideration if Thurrock's transformation programme is to be successful:

The ability to invest appropriately in transformation—including in communities

Being able to balance the demands of a national agenda with the importance of delivering on a local agenda

The ability to shift resource from one part of the system to another—e.g. from acute to community, from health to social care, from STP level to Place level to community level….

The loss of key individuals—the ability to continue to drive and deliver the agenda with people who feel passionately about it

The ability to demonstrate impact—particularly if models are more expensive to an organisation than the existing model

The lack of community buy-in or lack of involvement and engagement with communities leading to a lack of trust

The breakdown of partnership arrangements and relationships

The ability to overcome organisational sovereignty

The risk of being risk adverse…...

In Conclusion

Amongst the lessons learnt from our transformation journey to date is that change is constant and that permanent transformation is a natural state.

We have learnt that the **conditions for change** are essential for success and that they include:

- Leadership
- Strong relationships with key partners
- Permission to be innovative and challenge the status quo
- Permission to take risk

We have also learnt that system change is not quick, not easily measurable, and must be flexible enough to evolve. Rarely is significant change 'right first time'.

Our biggest challenge as we move forward is being able to lose control in order to transfer power to our staff and to our communities. The value we place on communities and their role in delivering system change is key to us being able to do this.

If you have any questions or queries about this paper or want to share your experiences with us, please get in touch:

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